

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11859

CERTIFICATE OF DEATH

11868
31

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hosp.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Woodsboro</i>	
3. NAME OF DECEASED (Type or print) <i>BERTHA</i>		First <i>A.</i>	Middle <i>AMBROSE</i>
4. DATE OF DEATH <i>November 25 1957</i>	Month	Day	Year
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 16 1881</i>
9. AGE (In years lost birthday) <i>76 yrs.</i>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
10c. BIRTHPLACE (State or foreign country) <i>Maryland</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles H. Eyer</i>		14. MOTHER'S M AIDEN NAME <i>Mary Jane Weller</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>- - -</i>	
17. INFORMANT <i>Mr. John A. Ambrose Jr., Woodsboro, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), slotting the underlying cause lost. (b) <i>Hypertensive Arteriosclerotic Cardio-Vascular Disease</i>		3 years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Walkersville</i> (County) <i>Maryland</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>June 15, 1957</i> to <i>Nov. 25, 1957</i> that I last saw the deceased alive on <i>Nov. 25, 1957</i> , and that death occurred at <i>1100 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ernest A. Dettbarn</i>		ADDRESS (Street, city or town, state) <i>Walkersville, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>ERNEST A. DETTBARN</i>		DATE SIGNED <i>Nov. 26, 1957</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/28/57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>United Brethren</i>		22d. LOCATION (City, town, or county) <i>Thurmont</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G.C. Barton</i>		24a. REC'D BY REGISTRAR <i>Elizabeth S. Heck</i> DATE <i>29 Nov. 1957</i>	
ADDRESS <i>Walkersville, Md.</i>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

BUREAU X-6

DEC 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11869

11860 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 6 Weeks			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 158 West All Saints Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Frederick			
3. NAME OF DECEASED (Type or print) SHEBRA		First LAWRENCINE	Middle AMBUSH		
4. DATE OF DEATH November 22, 1957	Month November	Day 22	Year 1957		
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH October 19, 1957		
		9. AGE (in years last birthday) yrs. 1 Months 3 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Lawrence T. Davis		14. MOTHER'S MAIDEN NAME Mary Frances Ambush			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None			
17. INFORMANT Mr. David E. Myers- Same as Item #1		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 754.4 DUE TO Acute Cardiac dilation INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Congenital Heart defect					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11/26/1957	
22a. BURIAL/CREMATION/REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 26, 1957		22c. NAME OF CEMETERY OR CREMATORIAL St. John's Cemetery	
22d. LOCATION (City, town, or county) Frederick				(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR Elizabeth Heck	
				24b. REGISTRAR'S SIGNATURE	
				DATE 26 Nov 1957	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11861

CERTIFICATE OF DEATH

11870

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burkittsville		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ROBERT		First ROBERT	Middle LEE	Last ARNOLD	4. DATE OF DEATH November 3, 1957	Month November	Day 3	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 22 Oct 1909	9. AGE (In years last birthday) 48	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Minutes 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George V. Arnold		14. MOTHER'S MAIDEN NAME Emma M. Ausherman						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-20-3275		17. INFORMANT Thomas D. Arnold (Same as Item #2)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 241X		Acute at. side heart decompensation		INTERVAL BETWEEN ONSET AND DEATH 1 hr		
		(b)		Bronchial Asthma + Thoro Pneumonia		3 days		
		(c)		Chronic Bronchial Asthma Myocarditis		2 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Old Rots disease with deformity						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day 19	Year 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Jefferson, Maryland	(County)	(State)
21. I certify that I attended the deceased from alive on <u>Nov 3, 1957</u> to <u>Nov 3, 1957</u> , and that death occurred at <u>3 P M</u> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE A. T. Brice						DATE SIGNED 11-4-57		
PHYSICIAN'S NAME (Type) A. T. Brice, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-6-57	22c. NAME OF CEMETERY OR CREMATORIAL Pleasant View Cemetery	22d. LOCATION (City, town, or county) Near Burkittsville, Maryland	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR Elizabeth B. Heck	24b. REGISTRAR'S SIGNATURE			
VS A15 (4) 15M 9/55				DATE 6 Nov 1957				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11862 CERTIFICATE OF DEATH

11871

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Hospital Since 10/27/57	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 900 Pine Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CLARA	Middle Marsh	Last AUSTIN
4. DATE OF DEATH	Month November	Day 8	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Sept 1904
9. AGE (In years last birthday) 53	10. IF UNDER 1 YEAR yrs. Months 53	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clement Marsh		14. MOTHER'S MAIDEN NAME Louella Foskett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT James R. Austin (Same as item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X		INTERVAL BETWEEN ONSET AND DEATH 2 years	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b) DUE TO			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/25/57, 1957 , to 11/27/57, 1957 , that I last saw the deceased alive on 11/28, 1957 , and that death occurred at 11:35 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>L. R. Schoolman</i>		ADDRESS (Street, city or town, state) M.D. 228 N. Market St., Frederick, Md.	
PHYSICIAN'S NAME (Type) L. R. Schoolman, M. D.		DATE SIGNED 11-9-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12/57	
22c. NAME OF CEMETERY OR CREMATORIAL Corbin Cemetery		22d. LOCATION (City, town, or county) Dudley, Mass.	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 12 Mar 1957	
		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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BUREAU V. S.

NOV 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11872

CERTIFICATE OF DEATH

Reg. Dist. No. 138

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Kempton		c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Rural - Kempton								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. Monrovia				d. STREET ADDRESS R.F.D. Monrovia		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Rufus E. Baker		First Rufus	Middle E.	Last Baker	4. DATE OF DEATH Nov. 16	Month Nov.	Day 16	Year 1957				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1870	9. AGE (In years lost birthday) 87 yrs.	IF UNDER 1 YEAR Months 87	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Montgomery Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME William Baker			14. MOTHER'S MAIDEN NAME Jemima Purdum									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Emma E. Baker, Monrovia, Md.		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, terminal DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Cerebro-vascular accident DUE TO (c) Arteriosclerosis, generalized, severe DUE TO 491X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Squamous cell carcinoma left hand DUE TO 20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.							20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 1955, to Nov. 16 , 1957, that I last saw the deceased alive on Nov. 16 , 1957, and that death occurred at 8:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE G. E. Meadors, M.D. M.D. 11/18/57												
PHYSICIAN'S NAME (Type) G. E. Meadors, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							22b. DATE THEREOF Nov. 19, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Providence Meth.	22d. LOCATION (City, town, or county) Kempton, Maryland.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molesworth		ADDRESS Damascus, Md.							24a. REC'D BY REGISTRAR Raymond L. Way	24b. REGISTRAR'S SIGNATURE Raymond L. Way	DATE 11/21/57	

WILLYA'S VILLAGE: A SMALL-SCALE MODEL OF INTEGRATED-EDUCATION 18

BUREAU V.

1957 LC RUN

REGELYÉD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11873

11863

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD.		b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN lb 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		d. STREET ADDRESS 75 MANCHESTER AVE.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSP				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) KATHLEEN		First J.	Middle J.	Last BOWERS	4. DATE OF DEATH 11	Month 11	Day 16	Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7-18-52	9. AGE (In years last birthday) 5 yrs.	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) M.D.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN BOWERS				14. MOTHER'S MAIDEN NAME SCATTERGOOD		CORDELIA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONIE JOHN BOWERS		17. INFORMANT 75 Manchester Ave. Westminster Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		RESPIRATORY FAILURE		INTERVAL BETWEEN ONSET AND DEATH			
DUE TO (c)		STAPHYLOCOCCAL PNEUMONIA							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frederick, Md.		(County) M.D.	(State) Md.
21. I certify that I attended the deceased from 11-11 , 19 57 , to 11-16 , 19 57 , that I last saw the deceased alive on 11-16 , 19 57 , and that death occurred at 9th A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Sidney J. Heldrich</i>						ADDRESS (Street, city or town, state) Frederick, Md.		DATE SIGNED 11/16/57	
PHYSICIAN'S NAME (Type) FRED J. HELDRICH M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-18-57		22c. NAME OF CEMETERY OR CEMETARY MEADOWBRANCH CEM. WESTMINSTER		22d. LOCATION (City, town, or county) WESTMINSTER		(State) M.D.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>David C. Bankard Westminster Md.</i>		ADDRESS 1118-57		24e. REC'D BY REGISTRAR 11-18-57		24f. REGISTRAR'S SIGNATURE <i>Elmer G. Shockey</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

8. SEONCE-100 THEATRICALS 2000

BUREAU V. 8

LET US RUN

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11864

CERTIFICATE OF DEATH

11874/31

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>15 M.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Md I.O.O.F. Home</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
3. NAME OF DECEASED (Type or print) <i>Howard</i>		d. STREET ADDRESS <i>3012 Christopher Avenue</i>	
4. DATE OF DEATH <i>Nov 26 1957</i>	Month <i>Nov</i>	Doy <i>26</i>	Year <i>1957</i>
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Feb. 13, 1880</i>
8. AGE (In years lost birthday) <i>77</i>	9. IF UNDER 1 YEAR Months <i>77</i>	10. IF UNDER 24 HRS. Hours <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Paper Hanger</i>		10b. KIND OF BUSINESS OR INDUSTRY	
10c. FATHER'S NAME <i>Louis Bromwell</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. MOTHER'S MAIDEN NAME <i>Anna Brooks</i>	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>1776</i>		15. SOCIAL SECURITY NO. <i>216-32-7273</i>	
16. INFORMANT <i>Mrs. Mary L. Bromwell, I.O.O.F. Home</i>		17. INFORMANT <i>Mrs. Mary L. Bromwell, I.O.O.F. Home</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1776</i> <i>Ischaemic Thrombosis</i>			
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.</i> <i>Chronic myocarditis</i>			
DUE TO <i>(b)</i> <i>Chronic myocarditis</i>			
DUE TO <i>(c)</i> <i>Carcinoma prostate</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>278 hours</i> <i>3 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan. 1, 1957</i> to <i>Nov. 26, 1957</i> that I last saw the deceased alive on <i>Nov. 26, 1957</i> and that death occurred at <i>11:55 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wm. M. Smith</i>		ADDRESS (Street, city or town, state) <i>Baltimore, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>William M. Smith</i>		DATE SIGNED <i>Nov 26 1957</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/29/57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Parkwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road.</i>	
24a. REC'D BY REGISTRAR DATE <i>NOV 29 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Ely Techy</i>	

CERTIFICATE OF DEATH

WISCONSIN

DEATH

REGISTRATION

NUMBER

NAME

SEX

AGE

CAUSE

DEATH

TIME

PLACE

TIME

DEATH

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11865 11875

11865 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13, 14, Film G222 11-25-57 et

Reg. Dist. No. 13

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Bartonsville, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William		First Middle Last Brown	4. DATE OF DEATH Month Nov. 11, 1957
5. SEX Male	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1893? Dec 11-1893 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1st. W.W. 213-76-0581	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 982 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Stab wound, left side of chest; did not penetrate lung or heart. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.O. Thomas</i>		DATE SIGNED 11/14/57	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-57	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Fairview		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks 111 Frederick, Md.		24a. REC'D BY REGISTRAR DATE 19 Mar. 1957	
		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

WISCONSIN STATE HIGHWAY - DIVISION OF
VEHICLE EXAMINER'S CERTIFICATE OF REGISTRATION

RECEIVED
BUREAU V. S.
NOV 20 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11876

11866

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b 50 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 165 B & O Avenue		d. STREET ADDRESS 165 B & O Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First SUSAN	Middle DOROTHY	Last BURRISS
4. DATE OF DEATH	Month November	Day 8	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31 Aug 1894
9. AGE (In years last birthday) 63	10. IF UNDER 1 YEAR yrs. Months	11. IF UNDER 24 HRS. yrs. Days	12. HOURS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Canning Factory	11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles F. Williams	14. MOTHER'S MAIDEN NAME Henrietta Williams		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No	16. SOCIAL SECURITY NO. 219-07-4910	17. INFORMANT Charles C. Burriss	Address (Same as item #1)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X			
DUE TO Cerebral Hemorrhage			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b) Hypertension			
DUE TO 4 days			
DUE TO 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-30, 1957 to 11-4, 1957 that I last saw the deceased alive on 11-4, 1957 , and that death occurred at 7 A M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 30 W. All Saints St., Fred'k, Md. DATE SIGNED 11-8-57			
ACTUAL SIGNATURE U. G. Bourne Jr.			
PHYSICIAN'S NAME (Type) U. G. Bourne, Jr., M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-11-57	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 12 Nov 1957	24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 2 and 4 should be filed with the regular prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

NOV 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11877

11893

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD #2 Frederick		c. LENGTH OF STAY IN 1b 21 years				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Jeanne	Middle Frances	Last Bussard			
4. DATE OF DEATH Month Nov	Day 11	Year 1957				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1936			
9. AGE (In years last birthday) 21 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME C. Lease Bussard	14. MOTHER'S MAIDEN NAME Frances L. Thomas					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT C. Lease Bussard	Address RFD# 2 Frederick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic glomerulonephritis DUE TO (c) Bronchial pneumonia severe uremic pericarditis						
INTERVAL BETWEEN ONSET AND DEATH unknown						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491X						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick	(County) Md.	(State) Md.
21. I certify that I attended the deceased from <u>Nov 10</u> , 1954, to <u>Nov 11</u> , 1957, that I last saw the deceased alive on <u>Nov 10</u> , 1957, and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.						
ACTUAL SIGNATURE Rex R. Martin	ADDRESS (Street, city or town, state) 35E Church Frederick, Md. 11-12-57			DATE SIGNED		
PHYSICIAN'S NAME (Type) Rex R. Martin						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 13, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet	22d. LOCATION (City, town, or county) Frederick, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Bailey Jr.	ADDRESS Frederick, Md.	24a. REC'D BY REGISTRAR DATE 13 Nov 1957	24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

NOV 15 1970

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11878

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY FREDERICK		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b 5 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR RURAL		d. STREET ADDRESS OAK ORCHARD ROAD 1		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mr. Howard W. Cantwell		First	Middle	Last	4. DATE OF DEATH Nov. 9	Month	Day	Year 1957
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 28-1886		9. AGE (In years lost birthday) 71 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GENERAL STORE-OWNER-OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME LEWIS CANTWEAL		14. MOTHER'S MAIDEN NAME SARAH GREEN						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 817-32-5672		17. INFORMANT ANNA M. CANTWEAL		18. ADDRESS RURAL MARYLAND NEW WINDSOR		
18. CAUSE OF DEATH. [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X		DUE TO Dysabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 1 week				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		(Coma - Acidosis) Broncho-Pneumonia						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4910 Arteriosclerotic Heart Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		Month 19	Day	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 7A	(County) Frederick, Md	(State) 11/9/57
21. I certify that I attended the deceased from Nov. 8, 1957 to Nov. 9, 1957 that I last saw the deceased alive on Nov. 9, 1957 , and that death occurred at 7A M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Frederick, Md		DATE SIGNED 11/9/57		
ACTUAL SIGNATURE A. A. PEARRE		PHYSICIAN'S NAME (Type) A. A. PEARRE MD		22. BURIAL, Cremation or Removal (Specify) BURIAL		22b. DATE THEREOF 11/11/57	22c. NAME OF CEMETERY OR CREMATORIUM LINCOLN CEM	22d. LOCATION (City, town, or county) ELGINVILLE, MD
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Hartley, Jr., New Windsor, Md.		ADDRESS W. H. Hartley, Jr., New Windsor, Md.		24a. REC'D BY REGISTRAR Elizabeth Heck		24b. REGISTRAR'S SIGNATURE		

CERTIFICATE OF DEATH

LAW 1000

RECEIVED

FBI
BUREAU V. S.

NOV 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11868

CERTIFICATE OF DEATH

13113

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		d. STREET ADDRESS 3811 Decatur Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick City Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) DABNEY		First JAMES	Middle CARR	Last CARR	4. DATE OF DEATH Nov. 30	Month Nov.	Day 30	Year 1957
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1875	9. AGE (In years last birthday) 82	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS. Days 26	12. HOURS Hours 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Machine shop		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Alban Carr				14. MOTHER'S MAIDEN NAME Emma Agey				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 224-26-3860		17. INFORMANT Caldwell A. Carr		Address same as 2d		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO <i>Congestive heart failure</i>				INTERVAL BETWEEN ONSET AND DEATH 1 HR.		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO <i>Atherosclerotic heart disease</i>				10 yrs +		
DUE TO (c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 4 E. Church St	(County) Frederick	(State) Md.
21. I certify that I attended the deceased from 11/27 , 19 57 to 11/29 , 19 57 , that I last saw the deceased alive on 11/29/57 , 19 57 , and that death occurred at 11 P M, from the causes and on the date stated above. ACTUAL SIGNATURE Henry V Chase		ADDRESS (Street, city or town, state) 4 E. Church St						DATE SIGNED 11/30/57
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/2/57		22c. NAME OF CEMETERY OR CREMATORIUM Forest Oak		22d. LOCATION (City, town, or county) Gaithersburg, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE DEC 11 1957		24b. REGISTRAR'S SIGNATURE Elly Gacky		

BUREAU V. S.

DEC 11 1957

РЕГИСТР

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11879

11894 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY		Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		Maryland			
Frederick				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Fred.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS			
Rural-Braddock Heights		Approx. 3mos.		X2 Rural- Frederick		/ R.F.D. 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Vindobona Convalescent Home				/ R.F.D. 2					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
John		David	Crummitt		Nov.	1	19	57	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	
Male		White	Widower <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	June 18-1904	53			Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Quarry Foreman		Limestone quarry		Maryland		U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
George E. Crummitt				Mary E. Hanson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		214-10-1754		Mrs. John D. Crummitt-Route 2-Frederick-Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Branchogenic Carinoma							
162X DUE TO		1/2 month							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.									
{ (b)									
DUE TO									
{ (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. 19 p. m.		Month	Day	Year	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>Jan 1</u> , 1957, to <u>Nov 1</u> , 1957, that I last saw the deceased alive on <u>Oct 31</u> , 1957, and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)							DATE SIGNED
ACTUAL SIGNATURE <u>H. L. Fahrney</u>		M.D. 17 E. 2nd. St.							
PHYSICIAN'S NAME (Type)		Frederick-Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-3-1957		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick-Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Cline & Son</u>		ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR DATE 4 Nov 1957		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

NOV 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11880

11869

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 2 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Jefferson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First MARY	Middle ADELINE	Last CULLER	4. DATE OF DEATH	Month November 17,	Day Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8 April 1888	9. AGE (In years from birthday) 69 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. DAYS	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Morgan H. Remsburg		14. MOTHER'S MAIDEN NAME Martha A. Pettingall		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Paul Z. Culler (Same as item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.9		DUE TO Carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH undetermined			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO Primary site undetermined					
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 31 Oct., 1957, to 17 Nov., 1957, that I last saw the deceased alive on 17 Nov., 1957, and that death occurred at 3 A M, from the causes and on the date stated above. ACTUAL SIGNATURE Melvin E. Lea, M.D.				ADDRESS (Street, city or town, state)		DATE SIGNED 11-18-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-57		22c. NAME OF CEMETERY OR CREMATORIAL Lutheran Cemetery		22d. LOCATION (City, town, or county) Jefferson, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE 19 Nov. 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

CERTIFICATE OF DEATH

1957

NAME	SEX	AGE	DEATH DATE	DEATH PLACE	CAUSE OF DEATH	DEATH CERTIFICATE NO.
WILLIAM H. BROWN	Male	65	NOV 20 1957	At home	Cardiac arrest	18-1000
WITNESSED BY						
BUREAU Y. REC'D						
NOV 20 1957						
RECEIVED						

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11870

CERTIFICATE OF DEATH

Reg. Dist. No.

11881
131

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY FREDERICK							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b 26 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		d. STREET ADDRESS 330 PARK AVE.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Nov. 14		Month Day Year 1957							
3. NAME OF DECEASED (Type or print) EZRA	First OWEN	Middle DORSEY	Last	5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4/18/1883	9. AGE (In years less birthday) yrs. 74	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUTCHER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME JOHN M. DORSEY		14. MOTHER'S MARRIED NAME LOUISA SMITH		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. MOTHER Maiden Name Woodsboro, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 610X		DUE TO Chronic bronchitis		INTERVAL BETWEEN ONSET AND DEATH 10 days		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 260x Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		DATE 14 Nov 57			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 610X		(b) DUE TO Chronic hypertension + right benign hypertrophy prostate		(c) 260x Diabetes mellitus									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 260x Diabetes mellitus											
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) WOODSBORO		(County) WALKERSVILLE		(State) Md.			
21. I certify that I attended the deceased from 1 Aug , 1957, to 14 Nov , 1957, that I last saw the deceased alive on 13 Nov , 1957, and that death occurred at 3:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) WALKERSVILLE, Md.													
ACTUAL SIGNATURE James E. Stoner Jr.		M.D.		DATE SIGNED 14 Nov 57									
PHYSICIAN'S NAME (Type) JAMES E. STONER, Jr.													
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/17/57		22c. NAME OF CEMETERY OR CREMATORIAL MT. HOPE		22d. LOCATION (City, town, or county) WOODSBORO		(State) Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Eliz. B. Hecks		ADDRESS Woodlawn Cemetery, Woodsboro, Md.		24a. REC'D BY REGISTRAR 16 Nov 1957		24b. REGISTRAR'S SIGNATURE Elizabeth B. Hecks							
VS A15 (4) 15M 9/55													

CERTIFICATE OF DEATH

BUREAU V. S

NOV 18 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11895

CERTIFICATE OF DEATH

Reg. Dist. No.

11882

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Thurmont		c. LENGTH OF STAY IN 1b 70 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Thurmont	
d. STREET ADDRESS /		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Preston Earl Favorite		First Preston	Middle Earl
4. DATE OF DEATH November 1 1957	Month November	Day 1	Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1883
			9. AGE (In years last birthday) yrs. 74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) Maryland
		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marshall H. Favorite		14. MOTHER'S MAIDEN NAME Alexzenia A. Stitely	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 219-20-6826	17. INFORMANT Claud H. Favorite
		Address Thurmont, Md. RD2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X			
DUE TO 2 uremia			
INTERVAL BETWEEN ONSET AND DEATH 2 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio-vascular - renal disease 5 yrs.			
DUE TO (c) Arteriosclerosis ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1 1957 to Nov 1 1957 that I last saw the deceased alive on Oct 31 1957 , and that death occurred at 2:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M. Franklin Birely M.D.		ADDRESS (Street, city or town, state) Thurmont, Md.	
DATE SIGNED 11/1/57			
PHYSICIAN'S NAME (Type) Dr. F. Franklin Birely			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-3-57	22c. NAME OF CEMETERY OR CREMATORIUM United Brethren Cemetery
		22d. LOCATION (City, town, or county) Thurmont, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager & Son		ADDRESS Thurmont, Md.	24a. REC'D BY REGISTRAR DATE 5 57
		24b. REGISTRAR'S SIGNATURE Creager	

41-39017340-37140-30 ПРИМЕРЫ ЗАДАНИЙ

BUREAU V. 3

1957 5 100

REGELIV ED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11896 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11883

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Thurmont</i>		b. COUNTY <i>Frederick</i>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X2 Thurmont</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>1 E. Main</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Charlotte Marie Fisor</i>		First	Middle
4. DATE OF DEATH <i>November 17 1957</i>		Lost	Month Day Year
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 29, 1896</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housework</i>		11. BIRTHPLACE (State or foreign country) <i>lived with Brother Maryland</i>	
13. FATHER'S NAME <i>John D. Fisor</i>		14. MOTHER'S MADDEN NAME <i>Emma K. Taylor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Ross C. Fisor</i>		Address <i>Thurmont, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>(b)</i>			
DUE TO <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B. O. Thomas</i>		DATE SIGNED	
EXAMINER'S NAME (Type) <i>B. O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 19. 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Moravion Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Graceham, Fredk. Co. MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Granger</i>		ADDRESS <i>Thurmont, MD</i>	
24a. REC'D BY REGISTRAR <i>DATE NOV 21 '57</i>		24b. REGISTRAR'S SIGNATURE <i>Deutsch</i>	

WISCONSIN STATE INSURANCE COMMISSION
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STAG 2-101
1944-1951



BUREAU V. S.

NOV 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11884
131

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick Memorial Hospital Frederick County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 12 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x1 Thurmont, R.D. # 1.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First Harry	Middle W.	Last Firor	4. DATE OF DEATH	Month Nov.	Day 16	Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/76	9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Day worker		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Firor				14. MOTHER'S MAIDEN NAME Amanda Lightner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Franklin Firor		Address Thurmont, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
INTERVAL BETWEEN ONSET AND DEATH 34 hours 10 year							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Thurmont	(County)	(State)	
21. I certify that I attended the deceased from <u>11/15</u> , 1957, to <u>11/16</u> , 1957, that I last saw the deceased alive on <u>11/15</u> , 1957, and that death occurred at <u>4:20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Henry V. Chase</u>	M.D.						
PHYSICIAN'S NAME (Type) Henry V. Chase							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-19-57	22c. NAME OF CEMETERY OR CREMATORIUM Blue Ridge Cemetery	22d. LOCATION (City, town, or county) (State) Thurmont, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager Thurmont, Md.			24a. REC'D BY REGISTRAR NOV 21 1957	24b. REGISTRAR'S SIGNATURE Ely G. Shuck			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11897 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11885

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Myersville		c. LENGTH OF STAY IN lb years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS x2 Rural Myersville	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Albert P. Fisher		First Middle Last	4. DATE OF DEATH Nov. 2, 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/3/1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Doy Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sawmill operator		10b. KIND OF BUSINESS OR INDUSTRY sawmill	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Philip I. Fisher		14. MOTHER'S MAIDEN NAME Jane L. Guilbert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-05-9208 17. INFORMANT Mrs. Mamie Fisher, Myersville, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Coronary Thrombosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED November 2-1957
EXAMINER'S NAME (Type) B. O. Thomas			
22a. BURIAL OR CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 11/5/1957	22c. NAME OF CEMETERY OR CREMATORIUM Community Cemetery	22d. LOCATION (City, town, or county) Harmony, Fred. Co., Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.	24a. REC'D BY REGISTRAR DATE 4 Nov 1957 24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck		

BUREAU U. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11886

CERTIFICATE OF DEATH

Reg. Dist. No. 131

11872

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 32 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS 261 West Fifth Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First FLORENCE	Middle GERTRUDE	Lost FORD	4. DATE OF DEATH November 22, 1957	Month November	Day 22	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 10 Sept 1874	9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Zedoc Summers				14. MOTHER'S MAIDEN NAME Virginia Catherine Earp				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Arthur D. Ford (Same as item #2)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 48 hours 5 yrs +				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 228 N. Market St., Frederick, Md.	(County)	(State)	
21. I certify that I attended the deceased from <u>June</u> , 1957, to <u>Nov. 22</u> , 1957, that I last saw the deceased alive on <u>Nov. 22</u> , 1957, and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 228 N. Market St., Frederick, Md. DATE SIGNED ACTUAL SIGNATURE <u>B. O. Thomas</u> 11-25-57								
PHYSICIAN'S NAME (Type) B. O. Thomas, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-25-57	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland (State)				
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			ADDRESS		24a. REC'D BY REGISTRAR DATE 25 Nov. 1957	24b. REGISTRAR'S SIGNATURE Elizabeth B. Heels		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11898

CERTIFICATE OF DEATH

Reg. Dist. No.

11887

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buckeystown		c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buckeystown		d. STREET ADDRESS x2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First FANNIE	Middle WAGNER	Last GITTINGS	4. DATE OF DEATH	Month November	Day 16	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years from birth) 90	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Wagner			14. MOTHER'S MAIDEN NAME Emily Burgee					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. David A. Adams, Buckeystown, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x		DUE TO Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 35 yrs.				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) DUE TO Chronic cardiac vascular disease		(c)		10 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) North Market Street	(County)	(State)	
21. I certify that I attended the deceased from Nov 16 , 1957, to Nov 16 , 1957, that I last saw the deceased alive on Nov 16 , 1957, and that death occurred at 10:15A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) North Market Street								
ACTUAL SIGNATURE H. F. Kline								
PHYSICIAN'S NAME (Type) Dr. H. F. Kline, Sr.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 19, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS	24a. REC'D BY REGISTRAR 18 Nov. 1957	24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date of Birth		Cause of Death	
Place of Birth		Place of Death	
Name of Deceased		Name of Physician	
Address of Deceased		Address of Physician	
Name and Address of Person Filing		Name and Address of Person to whom Certificate is to be Mailed	
Signature of Person Filing		Signature of Person to whom Certificate is to be Mailed	
Date of Filing		Date of Mailing	
BUREAU V. REC'D.		NO. 00 1957	
RECEIVED			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11888

Reg. Dist. No.

CERTIFICATE OF DEATH

11899

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Thurmont		c. LENGTH OF STAY IN 1b 50 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Thurmont	
d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First ROY	Middle WEBSTER
4. DATE OF DEATH		Month Nov. II. 1957	Day Year 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 22, 1884
8. AGE (In years last birthday) 73 yrs.		9. IF UNDER 1 YEAR Months 73	10. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Contractors	
11. BIRTHPLACE (State or foreign country) Frederick Co. MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Grable		14. MOTHER'S MAIDEN NAME Harriette Mumford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 213-18-0727	
17. INFORMANT Mrs May Pryor Thurmont R.D.		Address Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Disease Congestive type DUE TO 434.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Thurmont, Md
20f. (City or town) Thurmont, Md		(County) Frederick Co. (State) MD	
21. I certify that I attended the deceased from Oct. 15, 1957 to Nov. 11, 1957 , that I last saw the deceased alive on Nov. 11, 1957 , and that death occurred at Thurmont from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thurmont, Md			
ACTUAL SIGNATURE <i>James K. Gray</i>		DATE SIGNED 11-12-57	
PHYSICIAN'S NAME (Type) James K. Gray			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Nov. 14, 1957		22b. DATE THEREOF U.B. Cemetery	
22c. NAME OF CEMETERY OR CREMATORIAL Thurmont, Md		22d. LOCATION (City, town, or county) (State) Thurmont, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md	
24a. REC'D BY REGISTRAR Nov 14 '57		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
this page should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED PERSON	NAME	SEX	AGE	DEATH DATE	TIME	CAUSE OF DEATH	DEATH CERTIFICATE NUMBER
WILLIAM J. HANLEY	HANLEY, WILLIAM J.	MALE	60	NOV 14 1957	10:45 AM	HEART DISEASE	11-2-97
ADDRESS							
1015 N. 10th Street, Milwaukee, Wisconsin							
BORN							
NOV 14 1897							
DIED							
NOV 14 1957							
CAUSE OF DEATH							
HEART DISEASE							
METHOD OF DEATH							
NATURAL							
TIME OF DEATH							
10:45 AM							
PLACE OF DEATH							
HOME							
NAME OF DOCTOR							
DR. JAMES J. KELLY							
SIGNATURE							
DR. JAMES J. KELLY							

BUREAU V. S.

NOV 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11889

11900

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-RFD#5		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Rural-RFD#5		d. STREET ADDRESS X2 Shookstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shookstown				d. STREET ADDRESS Shookstown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) DANIEL		First REUBEN	Middle GROVE	4. DATE OF DEATH November 26, 1957	Month November	Day 26	Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1866	9. AGE (In years from last birthday) 91	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME David Grove			14. MOTHER'S MAIDEN NAME Marietta Bopst					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Sallie J. Grove-Same as Item #1		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1			<i>Coronary Occlusion</i>			INTERVAL BETWEEN ONSET AND DEATH Minutes		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick	(County) Frederick	(State) Maryland	
21. I certify that I attended the deceased from Jan 23, 1957 to Nov 26, 1957 that I last saw the deceased alive on Jan 23, 1957 , and that death occurred at 5:00A M , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Professional Building		DATE SIGNED 11/27/57
ACTUAL SIGNATURE <i>B. O. Thomas</i>		M.D. Professional Building						
PHYSICIAN'S NAME (Type) Dr. B. O. Thomas, Sr.		Frederick, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 29, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. R. Etchison & Son, Frederick, Maryland</i>		ADDRESS		24a. REC'D BY REGISTRAR Elizabeth G. Heis		24b. REGISTRAR'S SIGNATURE		
VS A15 (4) 15M 9/55				DATE 29 Nov. 1957				

18. ECONOMIC-TECHNOLOGICAL STATE-INDICATOR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 111890

11873		11873		11873	
1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 16mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 918 North Market Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) REGINALD		First M.	Middle HARMON	4. DATE OF DEATH November 7, 1957	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 6, 1909	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Appliance		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Harmon		14. MOTHER'S MAIDEN NAME May Mohler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-10-3656		17. INFORMANT 918 N. Market St. Mrs. Nellie Harmon; Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>multiple pulmonary emboli & severe bronchial & w/</i> <i>420.0</i> DUE TO <i>pneumonia.</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>atherosclerotic heart disease</i> DUE TO <i>unKnown</i> (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Keyser, West Virginia	(County) (State)
21. I certify that I attended the deceased from <u>10-26</u> , 19 <u>57</u> , to <u>11-7-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-7-</u> , 19 <u>57</u> , and that death occurred at <u>9:30A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Rex R. Martin</u> M.D. 35 E. Church St., Frederick, Md. DATE SIGNED <u>11-7-57</u>					
PHYSICIAN'S NAME (Type) Rex R. Martin, M. D.					
22a. BURIAL, Cremation, Removal (Specify) Burial		22b. DATE THEREOF 11-9-57	22c. NAME OF CEMETERY OR CREMATORIUM Queen's Point Cemetery	22d. LOCATION (City, town, or county) Keyser, West Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS M. R. Etchison & Son, Frederick, Maryland	24a. REC'D BY REGISTRAR DATE <u>8 Nov. 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Herk</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

100-10000-502

MANHATTAN

MANHATTAN

BUREAU V. S.

NOV 12 1957

RECEIVED

69

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11874

CERTIFICATE OF DEATH

11891

Reg. Dist. No. 31

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Frederick MARYLAND		Maryland Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Frederick		x2 Melana	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
Frederick Memorial Hospital		1-----	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
			Harris
4. DATE OF DEATH	Month	Day	Year
	November	9	1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 26 1892
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months 3 Days 13 Hours 0 Min.	
65 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Secretary-Clerical		??	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Washington, D. C.		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Richard Mc Grath		Catherine Foley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		Unknown	
17. INFORMANT		Address	
J. Frank Harris		Melana, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Year	
163X		Dermonecrosis of lung, metastasis in	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		Thoracic & lumbar Vertebrae	
DUE TO (b)			
DUE TO (c)		Secondary Anemia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 5, 1957, to Nov 9, 1957, that I last saw the deceased alive on Nov 8, 1957, and that death occurred at 2:10 A. M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE B. O. Thomas		M.D. Frederick, Md. Nov. 9, 1957	
PHYSICIAN'S NAME (Type) B. O. Thomas		Frederick, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-57	
22c. NAME OF CEMETERY OR CREMATORIAL Potomac Church Cemetery.		22d. LOCATION (City, town, or county) Montgomery Co., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert C. Humphrey		ADDRESS Bethesda, Md.	
		24a. REC'D BY REGISTRAR NOV 12 1957	
		24b. REGISTRAR'S SIGNATURE G. G. G.	

87. 3500118—РУСАИ РО НЕМІСЬКИХ ВІДЕО ОНАДІЯННІ

BUREAU V. S.

NOV 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11892

11901 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS /	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Maurice		First E.	Middle Haupt, Sr.
4. DATE OF DEATH 11		Month 19	Day 19
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 10/4/1875		9. AGE (In years lost birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm tenant, ret.		10b. KIND OF BUSINESS OR INDUSTRY farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jacob N. Haupt		14. MOTHER'S MAIDEN NAME Amanda Wise	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Annie Haupt, Middletown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) Fractured Hip. (Nov 15 1957)		INTERVAL BETWEEN ONSET AND DEATH 7 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall on floor	
20c. TIME OF INJURY Hour a. m. 9 p. m. 7 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Middletown		(County) Frederick	
(State) Md.			
21. I certify that I attended the deceased from <u>Nov 15</u> , 1957, to <u>Nov 19</u> , 1957, that I last saw the deceased alive on <u>Nov 19</u> , 1957, and that death occurred at <u>M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>J. Elmer Harp</u>		ADDRESS (Street, city or town, state) Middletown	
PHYSICIAN'S NAME (Type) DR. J. Elmer Harp		DATE SIGNED 11-20-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11/22/1957	
22c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery		22d. LOCATION (City, town, or county) Middletown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.		24a. REC'D BY REGISTRAR DATE 23 Nov 1957	24b. REGISTRAR'S SIGNATURE Elizabeth Heck

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
this page should be detached for use as the burial-transit permit. Then, please remove carbon papers. Page 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		NAME OF MARRIED NAME	
JAMES R. HARRIS		JAMES R. HARRIS	
1910-1957		1910-1957	
1000 10th Street		1000 10th Street	
Sacramento, California		Sacramento, California	
Occupation		Occupation	
Retired		Retired	
Cause of Death		Cause of Death	
Cancer		Cancer	
Time of Death		Time of Death	
11:00 AM		11:00 AM	
Date of Birth		Date of Birth	
1910-10-26		1910-10-26	
Place of Birth		Place of Birth	
Sacramento, California		Sacramento, California	
Name and Address of Physician		Name and Address of Physician	
Dr. John C. Smith, 1000 10th Street, Sacramento, California		Dr. John C. Smith, 1000 10th Street, Sacramento, California	
Name and Address of Hospital		Name and Address of Hospital	
Sacramento General Hospital, 1000 10th Street, Sacramento, California		Sacramento General Hospital, 1000 10th Street, Sacramento, California	
Name and Address of Mortician		Name and Address of Mortician	
John C. Smith, 1000 10th Street, Sacramento, California		John C. Smith, 1000 10th Street, Sacramento, California	
Name and Address of Person Filing Certificate		Name and Address of Person Filing Certificate	
John C. Smith, 1000 10th Street, Sacramento, California		John C. Smith, 1000 10th Street, Sacramento, California	
Signature		Signature	
John C. Smith		John C. Smith	
Date		Date	
NOV 26 1957		NOV 26 1957	

BUREAU V. 2

NOV 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11902

CERTIFICATE OF DEATH

Reg. Dist. No.

11893

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Lantz, R.D.L Md.		c. LENGTH OF STAY IN 1b 20 Min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lantz Md. R.D.L		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Lantz Md. R.D.L	
d. STREET ADDRESS Lantz Md. R.D.L		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Hayden	Middle 	Last Hayden
4. DATE OF DEATH 11 27 57	Month 11	Day 27	Year 1957
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/27/57
9. AGE (In years last birthday) yrs. 	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS. Days 	12. Hours 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lantz Md. R.D.L		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Edward Hayden		14. MOTHER'S MAIDEN NAME Vera Keown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 	
17. INFORMANT Charles Edward Hayden Lantz Md. R.D.L		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY		INTERVAL BETWEEN ONSET AND DEATH —	
761.5 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO PREMATURITY (c) DUE TO PREMATURITY Separation of Placenta 2 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 Nov , 1957, to 27 Nov , 1957, that I last saw the deceased alive on 19 , and that death occurred at 1:45 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Blue Ridge Summit, Pa.	
ACTUAL SIGNATURE Harry H. Young Jr.		DATE SIGNED 27 Nov 57	
PHYSICIAN'S NAME (Type) Harry H. Young Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/28/57	
22c. NAME OF CEMETERY OR CREMATORIAL Green Hill		22d. LOCATION (City, town, or county) Waynesboro	
23. FUNERAL DIRECTOR'S SIGNATURE Walter G. Young		24a. REC'D BY REGISTRAR DATE Nov 29 57	
ADDRESS Waynesboro, Pa.		24b. REGISTRAR'S SIGNATURE Reed	

CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11875

CERTIFICATE OF DEATH

11894

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>16 weeks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Taneytown</i>		d. STREET ADDRESS <i>E. Baltimore Street</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Lydia</i>		First <i>Albert</i>	Middle <i>Hess</i>	Lost <i>62</i>	4. DATE OF DEATH <i>Nov 19</i>	Month <i>1957</i>	Day <i>19</i>	Year	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 18, 1895</i>		9. AGE (In years lost birthday) <i>62</i> yrs.	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Jasper Baker</i>		14. MOTHER'S MAIDEN NAME <i>Mary Brown</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>214-28-7327</i>		17. INFORMANT <i>Mr. Carroll C. Hess, Taneytown, Maryland</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>4 mo</i>			
153X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>153X</i>		DUE TO (b) <i>Carcinoma of the cecum</i>							
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19		Month <i>11</i>	Day <i>19</i>	Year <i>1957</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Taneytown</i>	(County) <i>Frederick</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>7/13/1</i> , 19 <i>57</i> , to <i>11/19</i> , 19 <i>57</i> that I last saw the deceased alive on <i>11/19</i> , 19 <i>57</i> , and that death occurred at <i>1 p</i> M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>4 E. Church St</i>			DATE SIGNED <i>11/19/57</i>
ACTUAL SIGNATURE <i>Henry V Chase</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>Henry V. Chase</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/22/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Lutheran Cemetery</i>		22d. LOCATION (City, town, or county) <i>Taneytown</i>		(State) <i>Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mervyn C. Fuss</i>		ADDRESS <i>Taneytown, Maryland</i>		24a. REC'D BY REGISTRAR <i>Elizabeth Heck</i>		24b. REGISTRAR'S SIGNATURE <i>Elizabeth Heck</i>			

11112 CERTIFICATE OF DEATH

BUREAU V. S.

NOV 25 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11903

CERTIFICATE OF DEATH

11895
31

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Yellow Springs		c. LENGTH OF STAY IN 1b 10 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION P.O.- Frederick- Route 3		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Charles	Middle William	Last Hoffman
4. DATE OF DEATH	Month Nov.	Day 28th	Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	8. DATE OF BIRTH 12-3-1895
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY Retail Grocery	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George J. Hoffman		14. MOTHER'S MAIDEN NAME Annie E. Topper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 219-20-2571	
17. INFORMANT Mrs. Charles W. Hoffman- Rt.3-Frederick		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on Nov. 26, 1957 , to Nov. 28, 1957 , that I last saw the deceased and that death occurred at 1 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9 East Church St.		DATE SIGNED	
ACTUAL SIGNATURE <i>W. H. Slusher</i>			
PHYSICIAN'S NAME (Type) Dr. Hamilton J. Slusher		Frederick-Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-1-1957	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. E. Cline & Son</i>		24a. REC'D BY REGISTRAR DATE 2 Dec 1957	
		24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Hepp</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the regular or prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11876

CERTIFICATE OF DEATH

Reg. Dist. No.

11896

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania		b. COUNTY Cumberland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carlisle		75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kriderick Memorial Hospital		d. STREET ADDRESS 206 Northwest Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle c.	Last Hoffman	4. DATE OF DEATH 11	Month /	Day /	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-21-88	9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Hoffman		14. MOTHER'S MAIDEN NAME Sarah E. Stauffer		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-21 , 19 57 , to 11-1 , 19 57 , that I last saw the deceased alive on 11-1 , 19 57 , and that death occurred at 1:35 A.M. , from the causes and on the date stated above. ACTUAL SIGNATURE J. A. Geare M.D. ADDRESS (Street, city or town, state) Frederick, Md. DATE SIGNED 11/1/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-4-57		22c. NAME OF CEMETERY OR CREMATORIAL Westminster		22d. LOCATION (City, town, or county) Cumberland County (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ray C. Hoffman		ADDRESS 219 N. Hanover St. Carlisle, Pa.		24a. REC'D BY REGISTRAR DATE 11-4-57		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

ВІД ЗНОВУДІЯ—ВІДДАМ їХ ТАКИХЩОУ СТАРІ СІДЛУДАМ.

BUREAU V.

1951 4 NOV

REGEI V E D

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11904

CERTIFICATE OF DEATH

11897

Reg. Dist. No.

138

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kemptown		c. LENGTH OF STAY IN 1b 13 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kemptown		d. STREET ADDRESS R.F.D. Monrovia		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. Monrovia				d. STREET ADDRESS R.F.D. Monrovia		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Jesse Raymond Joines		First	Middle	Last	4. DATE OF DEATH November 20	Month	Day	Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1884	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. Wilksboro, N.C.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Jesse Franklin Joines		14. MOTHER'S MAIDEN NAME Nancy L. -----						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Mrs William Gladhill, Monrovia, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH 5 years. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. 19 p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Damascus, Md.	(County)	(State)	
21. I certify that I attended the deceased from July 10, 1957 , to Nov. 20, 1957 , that I last saw the deceased alive on Nov. 19, 1957 , and that death occurred at 4:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED 11/20/57								
ACTUAL SIGNATURE James P. Kerr M.D.								
PHYSICIAN'S NAME (Type) James P. Kerr Damascus, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 22, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Montgomery Meth.		22d. LOCATION (City, town, or county) Clagettsville, Md.			(State)
23. FUNERAL DIRECTOR'S SIGNATURE Clara L. McLeanith		ADDRESS Damascus, Md.	24a. REC'D BY REGISTRAR DATE Nov. 21, 1957		24b. REGISTRAR'S SIGNATURE Raymond F. Day			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11877

CERTIFICATE OF DEATH

11898

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 30 yrs.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 320 North Bentz Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		
3. NAME OF DECEASED (Type or print) Nettie Gertrude Jones		d. STREET ADDRESS 320 North Bentz Street		
3. SEX Female	4. COLOR OR RACE Colored	5. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	6. DATE OF BIRTH Feb. 21-1876	
		7. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years lost birthday) 81 yrs.	
		9. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****	11. BIRTHPLACE (State or foreign country) Frederick Co. Md.	
13. FATHER'S NAME Wilson Morrison		14. MOTHER'S MAIDEN NAME Annie Thomas		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		
17. INFORMANT Ruth Ambush		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Cerebral Hemorrhage INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- 24 hrs lying cause lost. (b) Chr Cardio Renal Vascula Disease (c) 10 yrs		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-8 , 19 47 , to 11-24 , 19 57 , that I last saw the deceased alive on 11-23 , 19 57 , and that death occurred at 3:30 PM , from the causes and on the date stated above. ACTUAL SIGNATURE U.G. Bourne Jr. M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED
22a. BURIAL, CREMATION; REMOVAL (Specify) Burial		22b. DATE THEREOF 11-26-57	22c. NAME OF CEMETERY OR CREMATORIUM Fairview	22d. LOCATION (City, town, or county) Frederick, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III		ADDRESS Frederick, Md.	24a. REC'D BY REGISTRAR DATE 2 Dec. 1957	
			24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

REGELIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11899

11905

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick,		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Walkersville, Md.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Walkersville, Md. x 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Green St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle Ervin	Last KANODE	4. DATE OF DEATH	Month NOVEMBER	Day 2	Year 1957
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 8, 1896	8. AGE (In years lost birthday) 60 yrs.	9. IF UNDER 1 YEAR Months 11	Days 25	IF UNDER 24 HRS. Hours 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) employed by Ox Fiber Brush		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Martin Kanode		14. MOTHER'S MAIDEN NAME Ella Nora Graser					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. world was 1 219-12-2106		17. INFORMANT Mrs Edna M. Kanode, Walkersville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		Carcinoma, sigmoid colon				INTERVAL BETWEEN ONSET AND DEATH 8 months	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Recurrent cystitis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Walkersville, Md.	(County) (State)
21. I certify that I attended the deceased from		1 Apr. 2, 1957, to		2 Nov. 1957, that I last saw the deceased alive on		ADDRESS (Street, city or town, state) Walkersville, Md. 2 Nov. 57.	
ACTUAL SIGNATURE James H. Morris Jr.				DATE SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Nov. 5, 1957		22c. NAME OF CEMETERY OR CREMATORIUM BALTIMORE NATIONAL Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert C. Healey		ADDRESS Frederick, Md.		24a. REC'D BY REGISTRAR DATE 5 Nov. 1957		24b. REGISTRAR'S SIGNATURE Elizabeth L. Heck	

CERTIFICATE OF DEATH

NOV 6 1957

BUREAU V. E.

NOV 6 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11906 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11906
131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville-Rural		c. LENGTH OF STAY IN 1b Minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Urbana		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Frederick-Rural RD#2	
3. NAME OF DECEASED (Type or print) MARGARET		First MARGARET	Middle REBECCA
3. NAME OF DECEASED (Type or print) MARGARET		Last KANODE	4. DATE OF DEATH November 9, 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 19 Aug 1906	9. AGE (In years (at birthday) 51 yrs.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME George W. O'Bryan		14. MOTHER'S MAIDEN NAME Lillie Kolb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-05-6516	17. INFORMANT Ralph G. Kanode, Jr., Frederick, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (g), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Skull		INTERVAL BETWEEN ONSET AND DEATH months	
816X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Crushed skull			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto collision	
20c. TIME OF INJURY Hour 11 a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 18
		20f. (City or town) Frederick, Md.	(County) Frederick
		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE B. O. Thomas		DATE SIGNED 11-12-57	
EXAMINER'S NAME (Type) B. O. Thomas, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-13-57	22c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery
		22d. LOCATION (City, town, or county) Frederick, Maryland	(State)
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR Elizabeth L. Heck	24b. REGISTRAR'S SIGNATURE Elizabeth L. Heck
		DATE 12 Mar 1957	

RECEIVED BY THE STATE GOVERNMENT OF SASKATCHEWAN - SASKATOON - 1957

BUREAU V. S.

NOV 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11907 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11901
131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville-Rural		c. LENGTH OF STAY IN 1b Minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Urbana		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#2	
3. NAME OF DECEASED (Type or print) RALPH GRAYSON KANODE		d. STREET ADDRESS Araby	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 13 Feb 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Oil Company	
10c. FATHER'S NAME Jacob M. Kanode		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-2688	
17. INFORMANT Ralph G. Kanode, Jr., Frederick, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture skull			
816X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed chest			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto collision	
20c. TIME OF INJURY Month, Day, Year Hour p. m. 11/9 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 30		20f. (City or town) (County) (State) Maryland Frederick Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 11-12-57			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 11-13-57	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 12/11/57	
		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED BY MAIL TO STATE OF MARYLAND - BUREAU OF INVESTIGATION - DEPARTMENT OF STATE

BUREAU V.

NOV 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11878

CERTIFICATE OF DEATH

11902

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 3 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 911 Shawnee Drive		d. STREET ADDRESS 911 Shawnee Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle CALVIN	Last KEENEN	4. DATE OF DEATH November 12, 1957	Month November	Day 12	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH March 29, 1888	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager-Office(Retired)		10b. KIND OF BUSINESS OR INDUSTRY Lime Company		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Keeney				14. MOTHER'S MAIDEN NAME (First name unknown) Beard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-07-0950		17. INFORMANT Mrs. Ruth S. Keeney,		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1				INTERVAL BETWEEN ONSET AND DEATH Minutes Coronary Occlusion			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)							
DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 1945 to Nov. 12, 1957 , that I last saw the deceased alive on Aug. 10, 1957 , and that death occurred at 8:00A M , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Professional Bldg. DATE SIGNED 11/14/1957							
ACTUAL SIGNATURE B. Thomas M.D.							
PHYSICIAN'S NAME (Type) Dr. B. O. Thomas, Sr. North Market St., Frederick, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 15, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Hope Cemetery		22d. LOCATION (City, town, or county) Woodsboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE 14 Nov 1957	
						24b. REGISTRAR'S SIGNATURE Elizabeth G. Herk	

U. S. BUREAU OF INVESTIGATION

NOV 15 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11903

11908

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Frederick MARYLAND		Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Walkersville	c. LENGTH OF STAY IN 1b 9 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Walkersville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First	Middle
PERCY		Roy	KEENEY
4. DATE OF DEATH	Month	Day	Year
Nov.	21	1957	
S. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
m	w		July 22, 1883
9. AGE (In years last birthday) 74 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief engineer	11. KIND OF BUSINESS OR INDUSTRY Heating plant	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Solomon P. Keeney	Mary Beard		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
		- Mrs. Alta Keeney, Walkersville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic cardio-vascular disease DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 1 hour Several years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2608 Diabetes mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY	Month, Doy, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Hour o. m. p. m.	19	While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 15, 1957, to Nov. 21, 1957, that I last saw the deceased alive on October 30, 1957, and that death occurred at 6:00 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE	ADDRESS (Street, city or town, state) Walkersville, Nov 22/57		
PHYSICIAN'S NAME (Type)	DATE SIGNED		
ERNEST A. DETTBARN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/24/57	22c. NAME OF CEMETERY OR CREMATORIAL Rocky Hill	22d. LOCATION (City, town, or county) Mr. Woodsboro
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Barton, Walkersville, Md	ADDRESS	24a. REC'D BY REGISTRAR DATE 25 Nov 1957	24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU Y.
RECEIVED
NOV 26 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11909

11909

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown		c. LENGTH OF STAY IN 1b 1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown		d. STREET ADDRESS 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Annie	Middle Amelia	Lost	4. DATE OF DEATH	Month Nov.	Day 3	Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/1/1869	9. AGE (In years lost birthday) 88 yrs.	IF UNDER 1 YEAR Months 88	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Horatio B. Kefauver		14. MOTHER'S MAIDEN NAME Mary Glessner							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Roscoe Remsberg, Middletown, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH Suddenly					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. {		(b) DUE TO Arterio-sclerosis							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) Middletown		(County) Middlesex	(State) Md.
21. I certify that I attended the deceased from July , 1955, to Nov 3 , 1957, that I last saw the deceased alive on Oct 27 , 1957, and that death occurred at 10:40 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Middletown		DATE SIGNED Nov. 11-4-57			
ACTUAL SIGNATURE J. Elmer Harp		M.D.							
PHYSICIAN'S NAME (Type) Dr. J. Elmer Harp		Middletown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11/6/1957		22c. NAME OF CEMETERY OR CREMATORIUM Reformed Cemetery		22d. LOCATION (City, town, or county) Middletown, Md.		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.		ADDRESS		24a. REC'D BY REGISTRAR 7 Nov. 1957		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WARMING STAYS DEDICATED TO THE MASTERS OF MASTERS

BUREAU V. S.

NOV 12 1957

REGELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11905

11879 CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Days		b. COUNTY Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. STREET ADDRESS 515 Fairview Ave.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Home for the Aged	
3. NAME OF DECEASED (Type or print) KATHERINE		(ALSO KNOWN AS CATHERINE) ELIZABETH KEPLINGER		DATE OF DEATH November 13, 1957	Month Day Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 26, 1873	9. AGE (In years last birthday) 84	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John H. Keplinger		14. MOTHER'S MAIDEN NAME Mary Herring		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Home for the Aged, Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Subarachnoid hemorrhage DUE TO Hypertension (c)					
INTERVAL BETWEEN ONSET AND DEATH 2 wks.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. Professional Bldg.	
20f. (City or town) —		(County) —		(State) —	
21. I certify that I attended the deceased from 3 Nov , 1957, to 13 Nov , 1957, that I last saw the deceased alive on 12 Nov , 1957, and that death occurred at 2:00A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) —					
ACTUAL SIGNATURE Charles H. Conley, Jr. DATE SIGNED 11/13/57					
PHYSICIAN'S NAME (Type) Dr. Charles H. Conley, Jr. North Market Street, Frederick, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 16, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery	
22d. LOCATION (City, town, or county) Middletown, Maryland		(State) —			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS —		24a. REC'D BY REGISTRAR DATE 14 Nov 1957	
				24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.
NOV 15, 1957
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11906

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen		b. COUNTY Baltimore Co.	
c. LENGTH OF STAY IN 1b 29 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital		d. STREET ADDRESS 7929 Redmore Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Peter	Middle	Last Kradz
4. DATE OF DEATH	Month November	Day 12	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1892
9. AGE (In years last birthday) 65	10. IF UNDER 1 YEAR yrs. Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer	10b. KIND OF BUSINESS OR INDUSTRY Koester's Bakery	11. BIRTHPLACE (State or foreign country) Austria	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Michael Kradz	14. MOTHER'S MAIDEN NAME Kata Bjelis		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 212-09-4566	17. INFORMANT Records of Victor Cullen State Hospital	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X		INTERVAL BETWEEN ONSET AND DEATH 1 yr. ?	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		DUE TO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 14 , 1957, to Nov. 12 , 1957, that I last saw the deceased alive on Nov. 12 , 1957, and that death occurred at 7:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cullen, Md. DATE SIGNED Nov. 12, 1957			
ACTUAL SIGNATURE T. F. Vestal			
PHYSICIAN'S NAME (Type) T. F. Vestal			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-16-57	22c. NAME OF CEMETERY OR CREMATORIAL Holy Rosary Cem.	22d. LOCATION (City, town, or county) Baltimore, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE Suey & Zeiler Inc.		ADDRESS 1901 Eastern Ave	24a. REC'D BY REGISTRAR NOV 15 1957 DATE 24b. REGISTRAR'S SIGNATURE G. F. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

2501 ST. AON

RECEIVE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										11911	11907	
										Reg. Dist. No.	131	
1. PLACE OF DEATH a. COUNTY Frederick b. FOR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown c. LENGTH OF STAY IN 1b Life					2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE Maryland b. COUNTY Frederick c. FOR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown d. STREET ADDRESS 1							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MARY		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year				
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 1 Nov 1892	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Adamstown, Maryland			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Jesse Krieg					14. MOTHER'S MAIDEN NAME Ruth Padgett							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Ruth A. Krieg (Same as item #1)		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH 15 minutes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour a. m. 19 p. m.		Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frederick (County) Maryland (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>												
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								DATE SIGNED 22 Nov 1957		
EXAMINER'S NAME (Type) B. O. Thomas, M. D.												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-22-57		22c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick (State) Maryland						
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland					ADDRESS		24a. REC'D BY REGISTRAR DATE 21 Nov 1957		24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck			
VS. A15ME(5) 5M 9/55												

BUREAU V. S.

NOV 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film C223 11-27-57 et

11908

131

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 3 Days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 119 S. Market St. Honeywood Church Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ADA		First ELIZABETH		Middle LAMPE		4. DATE OF DEATH Month November		Day 18		Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 9, 1879		9. AGE (In years from birthday) 78		10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Uriah A. Lough		14. MOTHER'S MAIDEN NAME Margaret Reifsneider		Address									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		<i>Acute Coronary Thrombosis</i> several hrs.											
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		<i>Arteriosclerotic Heart Disease</i> 3 mos											
(c) DUE TO													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)											
20c. TIME OF INJURY Hour a. m. — 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from Nov 18 , 1957, to Nov 18 , 1957, that I last saw the deceased alive on Nov 17 , 1957, and that death occurred at 7:00A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)											
ACTUAL SIGNATURE <i>A. A. Pearre</i>		DATE SIGNED 11/19/1957											
PHYSICIAN'S NAME (Type) Dr. A. A. Pearre		Frederick, Maryland											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 21, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick,		(State) Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE 20 Nov 1957		24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Heck</i>							

BUREAU V. S.

1957 NOV 21

DECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12 FilmG222 11-18-57 et

11881

CERTIFICATE OF DEATH

Reg. Dist. No.

11909

141

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL		d. STREET ADDRESS 19 EAST F. STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First DAISY	Middle B	Last LAWSON	4. DATE OF DEATH	Month NOVEMBER	Day 3	Year 1957
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH MAY 26, 1906	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Hours 1	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most at working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Brunswick, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES H. BEARD		14. MOTHER'S MAIDEN NAME SARAH PAYNE		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT HUSBAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH 10-25-57 to 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE 11-3-57 DUE TO (c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)
21. I certify that I attended the deceased from OCTOBER 25, 1957 , to NOVEMBER 3, 1957 , that I last saw the deceased alive on NOVEMBER 3, 1957 , and that death occurred at 8:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frederick, Md. DATE SIGNED 11-3-57							
ACTUAL SIGNATURE A. A. Pearce	PHYSICIAN'S NAME (Type)						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Nov. 5-57	22c. NAME OF CEMETERY OR CREMATORIAL METHODIST	22d. LOCATION (City, town, or county) PETERSVILLE		(State) M.D.		
23. FUNERAL DIRECTOR'S SIGNATURE Elva J. Steele	ADDRESS		24a. REC'D BY REGISTRAR DATE 11-3-57	24b. REGISTRAR'S SIGNATURE Eugenia W. Burke			

CERTIFICATE OF DEATH

REG. NO. 1000

1957

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BUREAU V. S.

NOV 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11910

11912 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 131

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Frederick	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville-Rural	c. LENGTH OF STAY IN 1b Minutes				
c. STREET ADDRESS Near Urbana	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Frederick-Rural RD#2				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Urbana	d. STREET ADDRESS 1. Araby				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) CATHERINE ELIZABETH LINTON	4. DATE OF DEATH November 9, 1957				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 20 May 1907	9. AGE (In years for birthday) 50 yrs.	10. IF UNDER 1YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress	10b. KIND OF BUSINESS OR INDUSTRY Clothing Factory	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Rice	14. MOTHER'S MAIDEN NAME Ada Rebecca Ausherman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 219-07-1148	17. INFORMANT Ralph W. Linton (Same as item #2)	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 816X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH months		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto collision				
20c. TIME OF INJURY Hour 11 p. m. Month, Day, Year 11/9/57 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 90	20f. (City or town) Near Urbana	(County) Frederick	(State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE B. O. Thomas	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 11112-57			
EXAMINER'S NAME (Type) B. O. Thomas, M. D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-13-57	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick, Maryland	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland	ADDRESS	24a. REC'D BY REGISTRAR DATE 12 Nov 1957	24b. REGISTRAR'S SIGNATURE Elizabeth S. Heath		

WISCONSIN STATEMENT OF DEATH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU
RECEIVED
NOV 13 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11913

CERTIFICATE OF DEATH

11911

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont	
3. NAME OF DECEASED (Type or print) CHARLES		First CHARLES	Middle MICHAEL
3. NAME OF DECEASED (Type or print) CHARLES		First CHARLES	Last MACKLEY
4. SEX Male	5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. B. DATE OF BIRTH Aug. 3. 1870
8. DATE OF DEATH Nov. 17. 1957	Month 11	Day 17	Year 19
9. AGE (In years last birthday) 87	10. IF UNDER 1 YEAR Months 8	11. IF UNDER 24 HRS. Hours 7	12. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant	10b. KIND OF BUSINESS OR INDUSTRY Own Store	11. BIRTHPLACE (State or foreign country) Thurmont Fredk Co Md	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME James C. Mackley		14. MOTHER'S MAIDEN NAME Martha Hann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-18-2959	
17. INFORMANT		Address James H. Mackley Thurmont. Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Heart disease Chr. arteriosclerotic type INTERVAL BETWEEN ONSET AND DEATH 6 mos.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 15 , 19 57 to Nov. 17/16 19 57 , that I last saw the deceased alive on Nov. 17/16 , 19 57 , and that death occurred at 6 P.M. M, from the causes and on the date stated above. ACTUAL SIGNATURE James K. Gray M.D. Thurmont - Md DATE SIGNED 9/18/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 19. 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Blue Ridge Cem.		22d. LOCATION (City, town, or county) Thurmont. Fredk. Co. Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager Thurmont MD		ADDRESS 11913	
24a. REC'D BY REGISTRAR NOV 21 '57		24b. REGISTRAR'S SIGNATURE Alb. French	

41. ЗНОВИТЬСЯ – ПІДАТИ ВО ТВІРНЯЩІЙ СТАЦІЇ ОБЛАДНЯННЯ

1951 TO 1952

REGELVÆL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11914

CERTIFICATE OF DEATH

Reg. Dist. No. 11912

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville-Rural		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville-Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Doctor Perry Road				d. STREET ADDRESS Doctor Perry Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MABEL		First MAGDALENE	Middle MOCK	4. DATE OF DEATH November 27,	Month 1957	Day 27	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4 Sept 1957	9. AGE (In years last birthday) yrs. 2	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days 23	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Harrison Mock, Sr.		14. MOTHER'S MAIDEN NAME Catherine M. Shane					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Henry H. Mock, Sr. (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X		Branche Pneumonia				INTERVAL BETWEEN ONSET AND DEATH 1 day	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		DUE TO					
{ DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from		11-26	1957	to	11-27	1957	that I last saw the deceased alive on
21. I certify that I attended the deceased from		11-26	1957	to	1:30A	M, from the causes and on the date stated above.	ADDRESS (Street, city or town, state)
ACTUAL SIGNATURE U. G. Bourne Jr.		DATE SIGNED M.D. 30 W. All Saints St., Fred'k, Md. 11-27-57					
PHYSICIAN'S NAME (Type) U. G. Bourne, Jr., M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-29-57	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE 29 Nov. 1957	24b. REGISTRAR'S SIGNATURE Elizabeth L. Heck		

CERTIFICATE OF DEATH

BUREAU V-8

DEC 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11882

CERTIFICATE OF DEATH

11913
731

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Frederick Maryland		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Baltimore Md		Baltimore 3401-4	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
at home-105 Cornhill		1210 John Street	
3. NAME OF DECEASED (Type or print)		First	Middle
Lester Curtis Munoz		Le	ster
4. DATE OF DEATH		Month	Day
Nov 30/1953		19	
5. SEX		6. COLOR OF HAIR	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	
Dec 7-1868		38	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Dqs Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
none		none	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Baltimore-Tippsia		U. S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
William Parker Curtis		Ella Lerner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		10 Col. Wm. P. C. Munoz	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
C. Address		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
420.0		Congestive Heart Failure	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 mo.	
DUE TO		(b) Anterior-lateral Heart Disease	
DUE TO		7 yrs	
(c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/15, 1952, to 11/30, 1952, that I last saw the deceased alive on 11/15, 1952, and that death occurred at 5400 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE		Henry V Chase M.D. 4E Church St 12/1/52	
PHYSICIAN'S NAME (Type)		Henry V. Chase Frederick Md	
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF	
Burial Sep 4/53		22c. NAME OF CEMETERY OR CREMATORIUM	
22d. LOCATION (City, town, or county) (State)		Greenlawn Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Cleated Morris Co		108 W North St Baltimore Md	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE		1953	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME

NAME

NAME

BUREAU Y.

DEC 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11914

11883

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Frederick-Rural RD#5			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 1 Gambrill Park Road		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First SYLVIA	Middle ANN	Lost MYERS	4. DATE OF DEATH November 9,	Month 1957	Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3 Oct 1937		9. AGE (in years from birthday) 20 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Business Office		10b. KIND OF BUSINESS OR INDUSTRY Hood College		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph C. Pazdersky		14. MOTHER'S MAIDEN NAME Amy M. Bartgis					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-34-8451		17. INFORMANT Joseph C. Pazdersky (Same as item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175x		DUE TO Carcinomatosis - Abdominal		INTERVAL BETWEEN ONSET AND DEATH 1 yr. +			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) DUE TO Carcinoma of Ovary		1 1/2 yr.			
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Exploratory Laparotomy - Nov. 8.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____ Nov. 4, 1957, to _____ Nov. 9, 1957, that I last saw the deceased alive on _____ Nov. 8, 1957, and that death occurred at 3:15 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE Frank D. Worthington		ADDRESS (Street, city or town, state)		DATE SIGNED			
PHYSICIAN'S NAME (Type) Frank D. Worthington, M. D.		M.D. 228 N. Market St., Frederick, Md. 11-11-57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-12-57	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick, Maryland	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE 12 Nov 1957	24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck		

BUREAU V.

- - 1957 - NOV 13

REGELY ED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PMA3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11915 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11915

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rt. 80 near Urbana		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 80 near Urbana		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Buckeystown	
3. NAME OF DECEASED (Type or print) Charles Elijah Nayler		First	Middle	Lost	4. DATE OF DEATH Nov. 9 1957
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Oct. 19-1934	9. AGE (In years from birthday) 23 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Co. Laborer		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Frederick, Md.	
13. FATHER'S NAME Charles H. Nayler		14. MOTHER'S MAIDEN NAME Mary V. Bell Nayler		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes		16. SOCIAL SECURITY NO. Mar. 11-53	17. INFORMANT Mary V. Nayler	Address Rt. 4 Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last.		Fracture base of skull INTERVAL BETWEEN ONSET AND DEATH 8-1-			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto collision			
20c. TIME OF INJURY Hour a.m. 11/15/57 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 80	20f. (City or town) Rt. Urbana Frederick Md	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE B.O.Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11/12/57	
EXAMINER'S NAME (Type) B.O.Thomas Sr.					
220. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 11-57	22c. NAME OF CEMETERY OR CREMATORIUM Baptist St. Pauls	22d. LOCATION (City, town, or county) Della, Fred. Co. Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III		ADDRESS	24a. REC'D BY REGISTRAR DATE 12 Nov 1957 24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck		

BUREAU V. S

NOV 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11884

CERTIFICATE OF DEATH

11916

Reg. Dist. No. 13

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 5 mos.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 68 S. Marbit St.,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		
3. NAME OF DECEASED (Type or print) Nellie		First W	Middle Neibert	
4. DATE OF DEATH 11 8 1957		Lost	Month Day Year	
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1879	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Hampton Edward Saum		14. MOTHER'S MAIDEN NAME Mary Rebecca Rhodes		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. Ernest Stephens	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident		INTERVAL BETWEEN ONSET AND DEATH 2 days		
331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO				
DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1955 , to Nov. 3 1957 , that I last saw the deceased alive on Oct 15 1957 , and that death occurred at 6:30 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 35 E. Church Frederick Md 118
ACTUAL SIGNATURE Rex R. Martin		M.D.		DATE SIGNED 11-11-57
PHYSICIAN'S NAME (Type) Rex R. Martin				
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11-11-57	22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill	22d. LOCATION (City, town, or county) Hagerstown
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	24a. REC'D BY REGISTRAR DATE 12 Nov 1957	24b. REGISTRAR'S SIGNATURE Elizabeth L. Heck

CERTIFICATE OF DEATH

BUREAU V. S.

NOV 18 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11885 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11917

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b DOA				
c. TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Point of Rocks		d. STREET ADDRESS 7				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) WILLIAM LUPTON NEWTON		4. DATE OF DEATH November 30, 1957	Month Day Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 28 Jan 1880	9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY State Roads Commission	11. BIRTHPLACE (State or foreign country) Virginia			
13. FATHER'S NAME George William Newton		14. MOTHER'S MAIDEN NAME Margaret A. Barry Slack				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-0759	17. INFORMANT Address Miss Ocale C. Wright (Same as item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis						
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____						
DUE TO (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>B. O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 30 Nov 1957		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-2-57		22c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Cemetery		
22d. LOCATION (City, town, or county) Point of Rocks, Maryland		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE 2 Dec 1957		24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Heck</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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DEC 3 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11916 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11918
131

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville-Rural		c. LENGTH OF STAY IN 1b Minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Urbana		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#2	
3. NAME OF DECEASED (Type or print) First LILLIE Middle VIRGINIA Lost O'BRYAN		d. STREET ADDRESS Araby	
4. DATE OF DEATH November 9, 1957		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 16 Oct 1883
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nimrod Kolb		14. MOTHER'S MAIDEN NAME Mary Kolb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Melvin J. O'Bryan (Same as item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull INTERVAL BETWEEN ONSET AND DEATH 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Crossed Chest (c) Fracture of leg Minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto collision	
20c. TIME OF INJURY Month, Day, Year Hour 8 a.m. p. m. 11-13-57 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 80		20f. (City or town) (County) (State) W. Urbana Frederick MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE B. O. Thomas		DATE SIGNED 11-12-57	
EXAMINER'S NAME (Type) B. O. Thomas, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-13-57	
22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS DATE 12 Nov 1957	
24a. REC'D BY REGISTRAR Elizabeth L. Heck		24b. REGISTRAR'S SIGNATURE	

MANUFACTURED STATE OF PENNSYLVANIA - HARRISBURG - 1957
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V.

NOV 13 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11919

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monrovia R.F.D. 15 x 2.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS Lewisdale	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Calvin First Lee Middle Orem		4. DATE OF DEATH Month November 9 Day 19 Year 57	
5. SEX Male C		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 18, 1934	
9. AGE (In years last birthday) 23 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Willard L. Orem	
14. MOTHER'S MAIDEN NAME Mary Jane Llyes		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 220-26-4957		17. INFORMANT Address Oland L. Molesworth Demascus, Md.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 982X DUE TO Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Stab-wound located Aorta DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stab in upper rt. side of chest by switch blade knife	
20c. TIME OF INJURY Hour 9-30 m. Month, Day, Year II/9 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) A.M. Vets club		20f. (City or town) (County) (State) Frederick, Frederick Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> II/II/57 DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION: REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 12, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Pleasant Grove Damascus, Md.		22d. LOCATION (City, town, or county) Purdum, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molesworth		24a. REC'D BY REGISTRAR DATE 13 Nov 1957	
		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

BUREAU V. S

NOV 12 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11920

11917

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN 1b 4 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindabona Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First GRACIE	Middle PEARL	Last PANGLE
4. DATE OF DEATH	Month November	Day 26	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH January 18, 1890
8. AGE (In years last birthday) 67 yrs.	9. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS. DAYS 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles Ghwen		14. MOTHER'S MAIDEN NAME Jennie Wortman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Frederick N. Pangle—Same as Item #2	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), slotting the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 month 10 year 70 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Edema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 19, 1938, to Nov 26, 1957, that I last saw the deceased alive on Nov 26, 1957, and that death occurred at 3:35 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. East Second Street ACTUAL SIGNATURE <i>H. Lorraine Fahrney</i> PHYSICIAN'S NAME (Type) Dr. H. L. Fahrney Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 29, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Monocacy Cemetery	22d. LOCATION (City, town, or county) (State) Bealsville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 29 Nov. 1957	24b. REGISTRAR'S SIGNATURE Elizabeth L. Heels

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11918

CERTIFICATE OF DEATH

11921
131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D.#3		c. LENGTH OF STAY IN 1b Years				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bethel Road-Near Yellow Springs		e. STREET ADDRESS Bethel Road-Near Yellow Springs				
3. NAME OF DECEASED (Type or print) JOHN ROBERT KING		First JOHN	Middle ROBERT			
		Last PEOMROY, SR.	4. DATE OF DEATH November 6, 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1884			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Andrew Peomroy		14. MOTHER'S MAIDEN NAME Anna Lewis				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-30-8861	17. INFORMANT Mrs. Ida H. Peomroy, Frederick R.D.#3, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH Sudden				
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Coronary heart disease		4 years				
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Woodsboro	(County) Maryland	(State)
21. I certify that I attended the deceased from Aug. 1953 to Nov. 6, 1957 that I last saw the deceased alive on Nov. 2, 1957 , and that death occurred at 6:00A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) M.D. East Church Street		DATE SIGNED 11/8/1957
ACTUAL SIGNATURE <i>M. H. Slusher</i>		PHYSICIAN'S NAME (Type) Dr. H. J. Slusher		Frederick, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 9, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Hope Cemetery	22d. LOCATION (City, town, or county) Woodsboro (State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR Elizabeth G. Herk	24b. REGISTRAR'S SIGNATURE	
VS A15 (4) 15M 9/55		DATE 8 Nov. 1957				

MANUFACTURED BY THE GOVERNMENT OF CANADA—GARLAND MODE 74
CEMETECALE OF BEAN 210-11

BUREAU V. 3

NOV 12 1957

PEGEI V E D

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film G223 12-2-57 et

11922

11887

CERTIFICATE OF DEATH

Reg. Dist. No. 13

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 70 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crutchley Nursing Home-708 N. Market St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
f. STREET ADDRESS 708 N. Market St.			
3. NAME OF DECEASED (Type or print)	First Fannie	Middle M.	Last Ragan
4. DATE OF DEATH Nov. 6	Month 1957	Day 19	Year 57
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12-22-1872
9. AGE (In years lost 84 today) 84 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. DAYS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Ragan		14. MOTHER'S MAIDEN NAME Mary Jane O'Hara	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Floyd Reside-Williamsport-Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Coronary Thrombosis			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Chronic Myocarditis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 6, 1957, to Nov. 6, 1957, that I last saw the deceased alive on Nov. 6, 1957, and that death occurred at 4:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state)		DATE SIGNED 11-6-1957	
ACTUAL SIGNATURE Dr. Hamilton J. Slusher		M.D. 9 E. Church St.	
PHYSICIAN'S NAME (Type) Dr. Hamilton J. Slusher		Frederick- Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-9-1957	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son		ADDRESS Frederick-Maryland	
24a. REC'D BY REGISTRAR DATE 8 Mr. 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

CERTIFICATE OF DEATH

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NOV 12 1957

RECEIVED

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11923

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen		c. LENGTH OF STAY IN 1b 2129 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 757 W. Fayette St.	
3. NAME OF DECEASED (Type or print) Rasmus		First Rasmus	Middle Rasmussen
4. DATE OF DEATH November 1 1957		Month November	Day 1
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Jan. 4, 1900		9. AGE (In years last birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Window Cleaner		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Norway		12. CITIZEN OF WHAT COUNTRY? Norway	
13. FATHER'S NAME Rasmus Rasmussen, Sr.		14. MOTHER'S MAIDEN NAME Mary Johannsen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 112-07-8086	
17. INFORMANT Records of Victor Cullen State Hospital		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis far advanced DUE TO 002 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 6 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 3, 1952 , to Nov. 1, 1957 , that I last saw the deceased alive on Oct. 31, 1957 , and that death occurred at 4:15 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>T. F. Vestal.</i>		ADDRESS (Street, city or town, state) Cullen, Md. DATE SIGNED Nov. 1, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12/1/57	
22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill		22d. LOCATION (City, town, or county) Washington (State) D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. L. Creager & Son Thurmond Md.</i>		ADDRESS 24a. REC'D BY REGISTRAR DATE NOV 4 '57	
		24b. REGISTRAR'S SIGNATURE <i>Al. Seach</i>	

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE	DEATH PLACE	CAUSE OF DEATH	DEATH CERTIFICATE NUMBER
WILLIAM H. HARRIS						
50						
M						
1957						
HOSPITAL						
HEART DISEASE						
100-123456789						
BUREAU V. 3						
NOV 4 1957						
RECEIVED						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 this page should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 11920

11924

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lantz		c. LENGTH OF STAY IN 1b 60 yrs.	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lantz	
d. STREET ADDRESS /		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Clarence B. Ridenour		First Clarence	Middle B.
4. DATE OF DEATH Nov. 10 1957	Month Nov.	Day 10	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1891
9. AGE (In years lost at death) 66 yrs.	10. IF UNDER 1 YEAR Months 66	11. IF UNDER 24 HRS. Hours 24	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Own business	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Ridenour		14. MOTHER'S MAIDEN NAME Mary M. Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-03-7753	
17. INFORMANT Pauline E. Ridenour		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart disease - Coronary type DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 3 1957 to Nov. 10 1957 , that I last saw the deceased alive on Nov. 10 1957 , and that death occurred at 6 p.m. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Thurmont Md.	
ACTUAL SIGNATURE <i>James K. Gray.</i>		DATE SIGNED 11-11-57	
PHYSICIAN'S NAME (Type) James K. Gray		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-13-57	
22c. NAME OF CEMETERY OR CREMATORIAL United Brethren Cem		22d. LOCATION (City, town, or county) (State) Thurmont, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager Thurmont, Md.		24a. REC'D BY REGISTRAR DATE NOV 14 57	
		24b. REGISTRAR'S SIGNATURE Releveich	

CERTIFICATE OF DEATH

NAME

BUREAU V. S.

NOV 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11921

CERTIFICATE OF DEATH

11925

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY FREDERICK		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LIBERTYTOWN		c. LENGTH OF STAY IN 1b YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LIBERTYTOWN		d. STREET ADDRESS X2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First CHARLES	Middle PATRICK	Last RIORDAN	4. DATE OF DEATH Nov. 4 1957	Month Nov.	Day 4	Year 1957
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/1881	9. AGE (In years (on birthday) 76 yrs.	IP UNDER 1 YEAR Months 76	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER-RETired OWNER		10b. KIND OF BUSINESS OR INDUSTRY OWNER		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME CORNELIUS RIORDAN		14. MOTHER'S MAIDEN NAME BRIDGET O'CONNELL						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ANNA B. RIORDAN, LIBERTYTOWN MD		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Acute dilatation						INTERVAL BETWEEN ONSET AND DEATH years		
(b) DUE TO Chronic myocarditis								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Nov. 3, 1957 to Nov 4, 1957 that I last saw the deceased alive on Nov 3, 1957 , and that death occurred at 7 PM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Union Bridge Md		DATE SIGNED 11-5-57
ACTUAL SIGNATURE J. H. Legg				M.D.				
PHYSICIAN'S NAME (Type) Dr. Thomas H. Legg						Union Bridge, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 19/8/57		22b. DATE THEREOF 19/8/57		22c. NAME OF CEMETERY OR CREMATORIUM ST PETERS CEM		22d. LOCATION (City, town, or county) LIBERTYTOWN MD		(State)
23. FUNERAL DIRECTOR'S SIGNATURE DD Publications Libertytown Md		ADDRESS 100 Main Street, Libertytown, Md		24a. REC'D BY REGISTRAR DATE 8 Nov 1957		24b. REGISTRAR'S SIGNATURE Elizabeth H. Hedges		

BUREAU V. S.

NOV 12 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11922

CERTIFICATE OF DEATH

Reg. Dist. No.

11926

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont Rural		c. LENGTH OF STAY IN 1b 25 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Rural Thurmont	
d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine (Feller) Seipler		4. DATE OF DEATH November 18	
5. SEX Female		First Middle Last Catherine (Feller) Seipler	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Sept. 19.1879		9. AGE (In years lost birthday) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Fellers		14. MOTHER'S MAIDEN NAME Anna ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs Charles Carty Thurmont, R.D. Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		INTERVAL BETWEEN ONSET AND DEATH 3 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. 260X		 Hypertension DUE TO Arteriosclerosis	
DUE TO (b) myocardial ischemia, diabetes mellitus		DUE TO ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) myocardial ischemia, diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 16, 1957 to Nov. 18, 1957 , that I last saw the deceased alive on Nov. 18, 1957 , and that death occurred at II:15 A.M.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE M. Franklin Birely		DATE SIGNED 11/19/57	
PHYSICIAN'S NAME (Type) M. Franklin Birely		Thurmont, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 21. 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Blue Ridge Cem.		22d. LOCATION (City, town, or county) Thurmont, Fredk. Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE M.L.Creager & Son.		ADDRESS Thurmont, Md	
24a. REC'D BY REGISTRAR DATE NOV 21 57		24b. REGISTRAR'S SIGNATURE Q. C. Birely	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BT 290M18-574M107344ABD STATE OF ALABAMA

BUREAU V. 2

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1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11927

Reg. Dist. No. 131

FOR STATE
HEALTH DEPT.

11888

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										2	
1		MEDICAL EXAMINER'S CERTIFICATE OF DEATH										2	
FOR STATE HEALTH DEPT.		Reg. Dist. No. 131											
1 11888		1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)								
		Frederick MARYLAND			a. STATE Maryland b. COUNTY Frederick								
69		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
		Frederick			About 26 yrs.			Frederick					
1 11888		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?					
		Frederick Memorial Hospital			241 East Sixth St.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
1 11888		3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Doy	Year			
		Walter		Kable	Shank	November	24	1957					
1 11888		5. SEX		6. COLOR OR RACE	7. MARRIED	8. DATE OF BIRTH	9. AGE (In years ^{month} yrs.)	IF UNDER 1 YEAR	IF UNDER 24 HRS.				
		Male		White	<input checked="" type="checkbox"/>	Oct. 4- 1900	57	Months	Days	Hours	Min.		
1 11888		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
		Butcher			Meat Cutter Retail Grocery			Frederick, Co. Md.			U.S.A.		
1 11888		13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME								
		Charles B. Shank			Sarah Catherine Aumen								
1 11888		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT					
		No			214-10-4545			Mrs. Walter Shank,			241 E. Sixth Street Frederick, Md.		
1 11888		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured liver										I/2 hour	
1 11888		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)											
		DUE TO (c)											
1 11888		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		(Fire engine was in motion - M.V.)											
1 11888		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
					Caught between the hook and ladder turntable and tractor sections								
1 11888		20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)		
		II-30 a.m.		II/24 1957	While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input checked="" type="checkbox"/> of work <input type="checkbox"/>			Court St.		Frederick		Frederick Md.	
1 11888		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										DATE SIGNED	
1 11888		ACTUAL SIGNATURE		<i>B.O. Thomas</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		November 25, 1957		
							ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
1 11888		EXAMINER'S NAME (Type)											
		B.O. Thomas											
1 11888		22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)			
		Burial		11-27-1957		Harmony Ch. Breth. Cem.		Harmony		Maryland			
1 11888		23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
		<i>C.E. Cline & Son</i>		Frederick-Md.		Elizabeth L. Heck							
1 11888		VS. A15ME		DATE 27 Nov. 1957									
		5M 2/57											

WISCONSIN STATE DEPARTMENT OF HEALTH - BAPTIST HOSPITAL
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE FOR
THE HEALTH

DEATH CERTIFICATE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11928

Reg. Dist. No. 131

11923

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN 1b 1yr.-6days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR, INSTITUTION Vindabona Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dr. John William		First Sheetz	Middle Sheetz
4. DATE OF DEATH November 19, 1957	Month November	Day 19	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1885
9. AGE (In years last birthday) 72	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician	10b. KIND OF BUSINESS OR INDUSTRY Retired M.D.	11. BIRTHPLACE (State or foreign country) Penna.	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John L. Sheetz		14. MOTHER'S MAIDEN NAME Catherine E. Kalbach	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Vindabona Convalescent Home, Braddock Hgts., Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Influenza/ pneumonia			
480X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/16/57 , 1957, to 11/19 , 1957, that I last saw the deceased alive on 11/18 , 1957, and that death occurred at 10A M from the causes and on the date stated above. ADDRESS (Street, city or town, state) 228 N Market St			
ACTUAL SIGNATURE L. R. Schoolman		DATE SIGNED 11/18/57	
PHYSICIAN'S NAME (Type) Dr. L. R. Schoolman		Frederick, Maryland	
22a. BURIAL, CREMATION; REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 22, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM New Oxford Cemetery		22d. LOCATION (City, town, or county) (State) New Oxford, Adams Co., Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 20 Nov. 1957	
		24b. REGISTRAR'S SIGNATURE Elizabeth L. Heck	

BUREAU V. S.

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REGELIVE ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11924

CERTIFICATE OF DEATH

Reg. Dist. No.

11930

1. PLACE OF DEATH o. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Emmitsburg		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x1 Rural Emmitsburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Norman	Middle Mahlon	Last Six	4. DATE OF DEATH November 7,	Month 1957	Day Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 7, 1890		9. AGE (In years lost birthday) 67 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Six				14. MOTHER'S MAIDEN NAME Ida Stonesifer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-36-7151		17. INFORMANT Mrs. Ruth Six, R #2, Emmitsburg, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) coronary atherosclerosis - coronary heart disease - DUE TO 7 years (c) arteriosclerosis several years INTERVAL BETWEEN ONSET AND DEATH 1 hour							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Emmitsburg	(County)	(State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above. ACTUAL SIGNATURE W.R. Cade PHYSICIAN'S NAME (Type) W.R. Cade DATE SIGNED 11-8-57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/10/57	22c. NAME OF CEMETERY OR CREMATORIUM Keysville Cemetery	22d. LOCATION (City, town, or county) Keysville, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Merwyn C. Fuss		ADDRESS Merwyn C. Fuss Taneytown, Md.	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE John C. Fuss			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

CERTIFICATE OF DEATH

NO. 00000000

NAME

ADDRESS

CITY

STATE

ZIP

PHONE

BUREAU V. S

NOV 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11889

CERTIFICATE OF DEATH

11931

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF ALSO KNOWN AS DECEASED (Type or print) MARY JANE SMITH		4. DATE OF DEATH Last November	Month 17,
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George E. Shaffer		14. MOTHER'S MAIDEN NAME Mary E. Schultz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Charles W. Smith—Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 Days " " 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1, 1957 , to Nov. 17, 1957 , that I last saw the deceased alive on Nov. 17, 1957 , and that death occurred at 3:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. East Third Street, DATE SIGNED 11/19/1957			
ACTUAL SIGNATURE Dr. T. E. Stone		PHYSICIAN'S NAME (Type) Dr. T. E. Stone	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 20, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 22 Nov 1957	
		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 25 1977

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 225 11-29-57 ams MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11932
131

Reg. Dist. No.

11925

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) State Frederick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Bartonsville Rt. 6 Fred. Co. Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) State Police Barracks (B) Frederick, Md.		d. STREET ADDRESS *****		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bernard		First Thomas	Middle Snowden	4. DATE OF DEATH Sept. 27-1921	Month 9 — Doy 12 Year 1957
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 27-1921	9. AGE (in years last birthday) 36 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmers Helper		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Bartonsville-Fred. Co. Md.	
13. FATHER'S NAME Harry Snowden		14. MOTHER'S MAIDEN NAME Mary Bowie		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-26-5364		17. INFORMANT Address Harry Snowden Route 6 Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 322.0 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause first. Chronic Alcoholism (b) DUE TO Idiopathic Epilepsy (c) Spinal fluid for Alcohol 0.40					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>B.O.Thomas</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) B.O.Thomas Sr.					
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 16-57	22c. NAME OF CEMETERY OR CREMATORIAL Bartonsville	22d. LOCATION (City, town, or county) Bartonsville-Fred. Co. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks 111		ADDRESS Frederick, Md.	24a. REC'D BY REGISTRAR DATE 19 Nov. 1957		
			24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11926

CERTIFICATE OF DEATH

11933

147

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. SEX				6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday) yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. KIND OF BUSINESS OR INDUSTRY		12. BIRTHPLACE (State or foreign country)		13. CITIZEN OF WHAT COUNTRY?							
Frederick		Rural Mt. Airy		Lifetime		Maryland		James		Nov. 30 1957		Mole				Colored		Sep.		June 21, 1900		57 yrs.		Trackman		Railroad		Maryland		U.S.							
14. FATHER'S NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14. MOTHER'S MAIDEN NAME				15. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)				16. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				17. INFORMANT				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
John Waugh Spencer		Yes WWI + II		705-12-5576		Joseph P. Spencer		Mary Fossett Address				Rheumatic Heart Disease More than 2 years				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from		alive on		and that death occurred at		ADDRESS (Street, city or town, state)		ACTUAL SIGNATURE				W.B. Culwell M.D.				DATE SIGNED				april 1957, to nov 1957, that I last saw the deceased alive on nov 10, 1957, and that death occurred at 7 A. M., from the causes and on the date stated above.				11/30/57													
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR DATE				24b. REGISTRAR'S SIGNATURE																					
Burial		12-3-1957		New London		Frederick Co., Md.		L.M. Waltz, Winfield, Md.				REC'D 3 105				Clarice Hunkley																					

BUREAU V.

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RECEIVE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11927 CERTIFICATE OF DEATH 11934
Reg. Dist. No. 87

1. PLACE OF DEATH a. COUNTY FREDRICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY FREDRICK					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE		c. LENGTH OF STAY IN 1b YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE		d. STREET ADDRESS BUNKER HILL ROAD					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RURAL BUNKER HILL ROAD		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) WILLIAM JACOB STRINE		First	Middle	Last	4. DATE OF DEATH NOV 17 1954	Month	Day	Year			
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 10/31/1873	9. AGE (In years last birthday) 84	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. HRS. Hours 0	13. MIN. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWNER		11. BIRTH/PLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME JACOB W STRINE		14. MOTHER'S MAIDEN NAME SUSAN STUNTZ									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT NONE CARRIE D. STRINE UNION BRIDGE		Address MD					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0		General debility— Arterio sclerosis									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arterio sclerosis		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Union Bridge (State) Maryland					
21. I certify that I attended the deceased from 11-11-1957 to 11-17-1957 that I last saw the deceased alive on 11-11-1957 , and that death occurred at 11:30 PM , from the causes and on the date stated above. ACTUAL SIGNATURE J. N. Legg		ADDRESS (Street, city or town, state) Union Bridge, Maryland DATE SIGNED 11-18-57									
PHYSICIAN'S NAME (Type) Dr. Thomas H. Legg		M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 11/20/57		22b. DATE THEREOF 11/20/57		22c. NAME OF CEMETERY OR CREMATORIAL BEAVER DAM CEM. UNION BRIDGE RURHL		22d. LOCATION (City, town, or county) MD		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE D. B. Schutzenb Union Bridge, Md		ADDRESS		24a. REC'D BY REGISTRAR 11/19/57		24b. REGISTRAR'S SIGNATURE Leslie J. Reppe					
VS A15 (4) 15M 9/55											

CERTIFICATE OF DEATH

BUREAU V.

NO. 80 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11935

11928

CERTIFICATE OF DEATH

Reg. Dist. No. 131

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Harmony Grove		c. LENGTH OF STAY IN 1b 38 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Harmony Grove - Route 3	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William		First Henry	Middle Thomas-Sr.
4. DATE OF DEATH November 19		Month 19	Day Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	8. DATE OF BIRTH Jan. 19-1869
9. AGE (In years lost birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Zachariah G. Thomas	
14. MOTHER'S MAIDEN NAME Louise Grove		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 212-38-9869		17. INFORMANT Dr. Wm. H. Thomas-Jr. - <i>Jug Bridge Hill - Frederick Md. R.F.D.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 526X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Address INTERVAL BETWEEN ONSET AND DEATH 2 days ? 6 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on <i>11/18</i> , 1957, and that death occurred at <i>12:15 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>James B. Thomas</i> PHYSICIAN'S NAME (Type) Dr. James B. Thomas		ADDRESS (Street, city or town, state) DATE SIGNED Professional Bldg. Frederick-Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-21-1957	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery
22d. LOCATION (City, town, or county) Frederick		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C.E. Cline & Son</i>		ADDRESS Frederick-Maryland	24a. REC'D BY REGISTRAR DATE <i>20 Nov 1957</i>
			24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Heck</i>

81.31001730-107.1410 90 79347044820 8172 01407840

BUREAU V. S.

NOV 21 1957

REGELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11890

CERTIFICATE OF DEATH

11936

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Frederick				a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY	
Frederick				Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Frederick Memorial Hosp		x Walkersville			

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Tammie	Sue	Wenzel	23	Nov	24	1957

5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
Female	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	23 Nov 57	1	Months	Days
				Yrs.	Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Paul Elwood Wenzel, Jr.	Patricia Ann Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
(If yes, give war or dates of service)		Mrs. Paul E. Wenzel, Jr.	Walkersville

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 560.2	24 hrs.
DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)	
DUE TO	
(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
Prematurity	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 23 Nov 1957, to 24 Nov 1957, that I last saw the deceased alive on 24 Nov 1957, and that death occurred at 6:05 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state)
DATE SIGNED

ACTUAL SIGNATURE	M.D.	220 N. Market St.
PHYSICIAN'S NAME (Type)	A. M. Powell, Jr. M.D. Frederick, Md.	

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county)
Burial	11/25/57	Glade Cemetery	Walkersville
			Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
G. C. Barton	Walkersville, Md.	DATE 26 Nov 1957	Elizabeth G. Heck

2069191XV2			
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE CITY

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11937

Reg. Dist. No. 139

11929

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cullen</i>		c. LENGTH OF STAY IN 1b <i>2274 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Victor Cullen State Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
3. NAME OF DECEASED (Type or print) <i>Thomas Joseph Werner</i>		d. STREET ADDRESS <i>811 S. Glover St.</i>	
4. DATE OF DEATH <i>November 28 1957</i>	Month Day Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>Dec. 6, 1916</i>
8. AGED (In years last birthday) <i>40</i>		9. IF UNDER 1 YEAR yrs. Months Days	10. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <i>Laborer & Clerical</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Packing House</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Frank Werner</i>	
14. MOTHER'S MAIDEN NAME <i>Franciska Kocent</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>215-12-5782</i>		17. INFORMANT <i>Records of Victor Cullen State Hospital</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>002 X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 yrs.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO <i>Advanced Pulmonary Tuberculosis</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept. 7, 1951</i> , to <i>Nov. 28, 1957</i> , that I last saw the deceased alive on <i>Nov. 28, 1957</i> , and that death occurred at <i>9:15 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>T. F. Vestal</i>		ADDRESS (Street, city or town, state) <i>Cullen, Md.</i>	
22. PHYSICIAN'S NAME (Type) <i>T. F. Vestal</i>		DATE SIGNED <i>Nov. 28, 1957</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/2/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Stanslaus Cemetery</i>
22d. LOCATION (City, town, or county) <i>1300 Dundalk Ave, Baltimore, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marie Skalkowski</i>		24a. ADDRESS <i>1000 S. Fremont Ave</i>	24b. REC'D BY REGISTRAR DATE <i>DEC 4 '57</i>
		24b. REGISTRAR'S SIGNATURE <i>Q. L. French</i>	

31. SHOULD IT PREFER TO THE PREVIOUS STATE OF AYRSHIRE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11891

CERTIFICATE OF DEATH

11938

Reg. Dist. No. 31

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN lb 40 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE		d. STREET ADDRESS ELGER ST			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) W.H. Calow		First	Middle	Last	4. DATE OF DEATH Wilson	Month	Day	Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> JAN 15-1890	9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOVEL OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY CEMENT		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME WILLIAM W. WILSON		14. MOTHER'S MAIDEN NAME SUSAN HILTEBRIDGE		Address MD					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 213-03-1058		17. INFORMANT MRS WM WELLING		INTERVAL BETWEEN ONSET AND DEATH 5 days			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X		DUE TO Tuberculosis		DUE TO (Bronchial asthma)		INTERVAL BETWEEN ONSET AND DEATH 6 mo			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 		(b)		(c)					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491X									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Arteriosclerotic Heart Disease							
20c. TIME OF INJURY Hour o. m. p. m. 19		Month	Day	Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick, Md.	(County) MD	(State) MD
21. I certify that I attended the deceased from Nov. 18, 1957 to Nov. 21, 1957 that I last saw the deceased alive on Nov. 21, 1957 , and that death occurred at 845A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frederick, Md. DATE SIGNED 11/21/57									
ACTUAL SIGNATURE A. A. PEARRE		ADDRESS FREDERICK, MD.							
PHYSICIAN'S NAME (Type) A. A. PEARRE									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV 24-1957		22c. NAME OF CEMETERY OR CREMATORIUM LUTHERAN		22d. LOCATION (City, town, or county) UNIONTOWN		(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE DD Hartzler & Sons Union Bridge, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 26 Nov. 1957		24b. REGISTRAR'S SIGNATURE Elizabeth Heck			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED	SEARCHED	INDEXED	SERIALIZED	FILED
NOV 27 1957				
BUREAU V. S.				
NOV 27 1957				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11930 CERTIFICATE OF DEATH

11939
147
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Mt. Airy</i>		c. LENGTH OF STAY IN 1b <i>50 years</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Frederick</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>XI Rural - Mt. Airy</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Buffalo Road</i>						d. STREET ADDRESS <i>Buffalo Road</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Elsie</i>		First	Middle	Last	4. DATE OF DEATH <i>Wise</i>	Month	Day	Year	5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>NOV. 26 1881</i>	9. AGE (In years lost birthday) yrs. <i>75</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>	13. Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>											
13. FATHER'S NAME <i>James Thomas Tucker</i>		14. MOTHER'S MAIDEN NAME <i>Hannah Mary Slimmer</i>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. M.L. Grimes (Daughter)</i>		Address <i>Rt. 2 Mt. Airy, Md.</i>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260x</i>		DUE TO <i>Diabetes Mellitus</i>				INTERVAL BETWEEN ONSET AND DEATH <i>17 years</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i>		DUE TO <i>(c)</i>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour o. g. p. m. <i>19</i>		Month <i>Nov.</i>	Day <i>24</i>	Year <i>1957</i>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Nov. 9, 1957</i>	(County) <i>Frederick Co.</i>	(State) <i>Md.</i>								
21. I certify that I attended the deceased from <i>Nov. 9, 1957</i> , to <i>Nov. 9, 1957</i> , that I last saw the deceased alive on <i>November 2, 1957</i> , and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Mt. Airy, Md.</i>		DATE SIGNED <i>Nov. 9, 1957</i>									
ACTUAL SIGNATURE <i>W.B. Culwell</i>																	
PHYSICIAN'S NAME (Type) <i>W.B. Culwell</i>																	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-12-1957</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Woodsbury Grove</i>		22d. LOCATION (City, town, or county) <i>Frederick Co.</i>		(State) <i>Md.</i>									
23. FUNERAL DIRECTOR'S SIGNATURE <i>C.M. Waltz, Winfield, Md.</i>		ADDRESS <i>C.M. Waltz, Winfield, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 13 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Clarence Rankley</i>											

CERTIFICATE OF DEATH

Date of Birth

Name

Date of Birth

Place of Birth

Name

Place of Birth

Place of Birth

Name

BUREAU V.

NOV 13 1957

RECEIVED